



Project Focus

- Newark Beth Israel Medical Center Selected: DSRIP Project #8:
The Congestive Heart Failure (CHF) Transition Program
- Transitioning Into Transitional Care
 - Program Modeled After Project RED, A Best Practice Care Transition Program
 - Internet based data mining software used, provides early identification of patients at the point they enter the ED; notification to Team if patient presents who has been in-patient within 30 days
 - Opened The Transitional Care Center (TCC) as a safety net to provide high risk patients with medical monitoring and other support until they are able to get an appointment with their primary care provider
 - Initiated community based Lifestyle Classes which provide education reinforcement and peer support over a ten week period. Teaching is done by a team which includes nutritionist, social worker, pharmacist, and cardiac rehab therapist.
 - Since April 2014, 763 patient enrollments
 - DSRIP team has provided mentorship for others who are part of a broader initiative to change the way health care is delivered throughout the Barnabas Health Care System

Lessons Learned: Initial PDSA Cycle

Scheduling A Follow-Up Appointment Before Discharge

- Improvement Opportunity: Data collected in June 2014 showed that only a small proportion (17%) of DSRIP team active cases had a specific follow-up appointment with date and time set up prior to discharge.
 - Documentation most often looked like, “follow up with Dr. Kildare” but no date, time scheduled.
- Analysis demonstrated that lack of appointments not associated with day of the week; was consistently not done, regardless if discharged over weekend or during the week
 - Staff did not pre-schedule appointments, then on day of discharge, there is rush to go, and no appointment made—results in patients getting home, feeling OK, and not making appointment right away, follow up too late

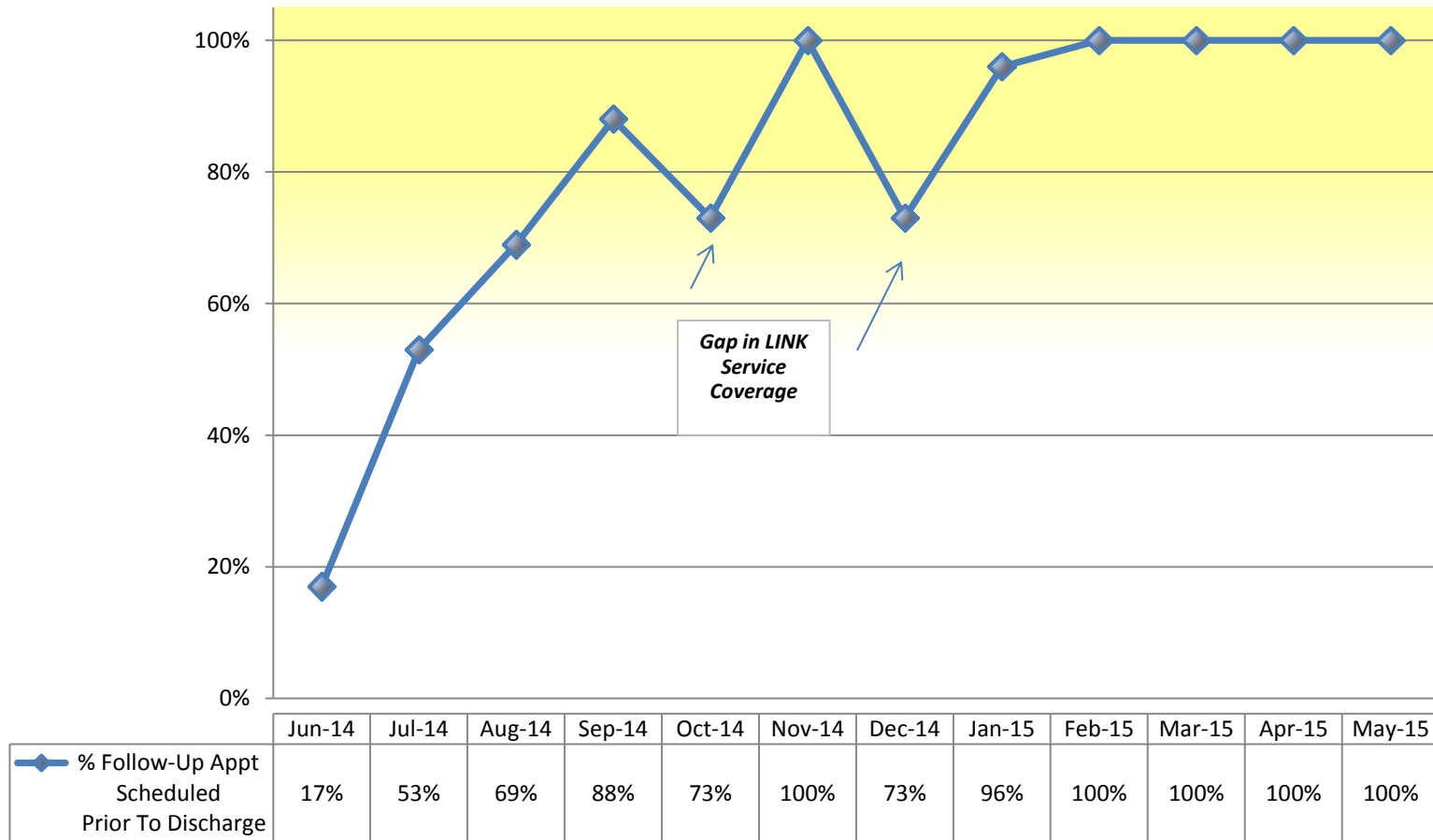
Process Change:

- Team med tech attends patient rounds on units, Bed Board meetings daily
 - If patient nearing discharge, appointment is made and documented in the record
 - If not discharged as anticipated, appointment is re-scheduled
 - LINK concierge service coordinates with Team; assists with appointment scheduling and transportation arrangements
 - Importance of scheduling actual appointment reinforced with education for attending physicians, resident staff, and patient care units
 - Early follow up appointments are now routinely made with Outpatient Patient Centered Medical Home Practices
- Current Status: Scheduling compliance has been at 100% for the last 4 months, the changes made are now permanently adopted. This approach is now being modeled throughout the medical center for other patient populations

Follow-Up Appointment Scheduled Before Patient Is Discharged

All Required Elements (Location, Date, Time)

Documented In Discharge Summary



n = 410 cases reviewed

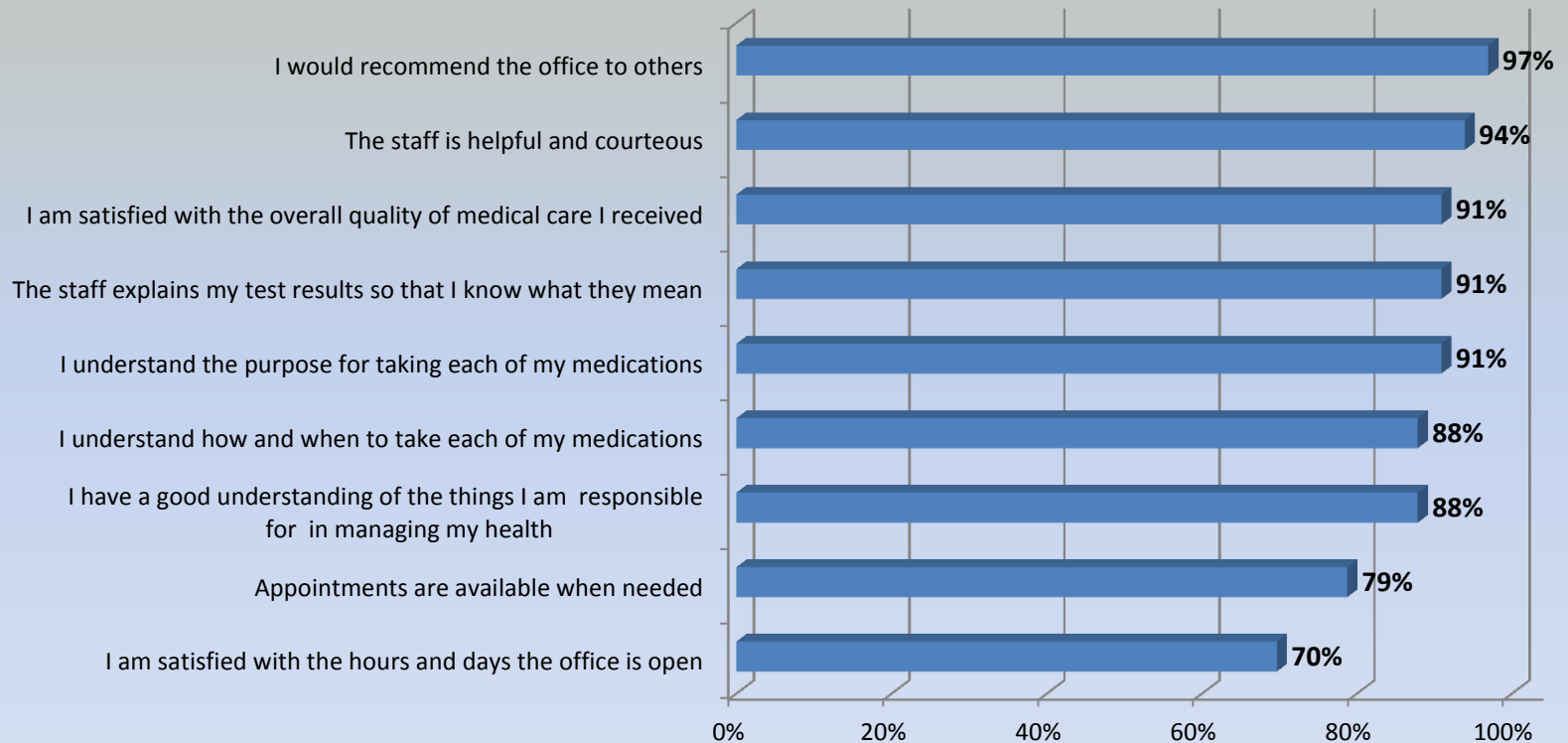
“Improvement Opportunity” Identified Using Patient Satisfaction Data

- Method: Survey conducted which combines some transitional care elements with survey elements currently used in Outpatient Adult Health Center
 - Either a free bus ticket or a free pass to the parking garage is offered as an incentive to complete the survey
 - Patients place anonymous surveys into a centralized drop-box for survey collection
- Improvement Opportunity: Data demonstrated two opportunities in which patients responded “strongly agree”
 - I understand the purpose for taking each of my medications (only 75%)
 - The staff explains my test results so that I know what they mean (only 80%)
- Process Changes Made: Implemented formal Teach-Back methodology with greater focus on:
 - Educating patients about rationale for medications, classes of medications
 - Explaining in detail about anticipated tests, lab work and the meaning of results

Patient Satisfaction Data – Outpatient Transitional Care Center (TCC)

% Top Ratings Of “Strongly Agree”

April-June 2015



April-June 2015; N = 33 Surveys

Transitional Care Center (TCC) Initial Patient Satisfaction Outcomes

- Compared to data collected (Oct-Dec 2014), the 2 patient satisfaction items targeted for improvement both show positive gains in (Apr-Jun 2015)
 - I understand the purpose for taking each of my medications (increased from 75% to 91%)
 - The staff explains my test results so that I know what they mean (increased from 80% to 91%)
- Unsolicited qualitative comments reflect these quantitative findings. Examples include:
 - “The staff explained my meds to me in terms I understand”
 - “ My medication understanding is much clearer and I will try my best to comply”
 - “ I am very satisfied with the service my mother got, everything was well explained and it helped me a lot”
 - “... They were very attentive to my questions and concerns”
 - “... They were so helpful and provided so much knowledge that helps me with my condition...”
 - “ The Transitional [Care Center] is a great place, I learned a lot and they are keeping me alive...”

Transitional Care Center (TCC) Data

Next Improvement Cycle

Goals For Next Improvement Cycle

- Improve ratings on lowest scoring item on TCC Patient Satisfaction (April – June 2015) Survey
 - I am satisfied with the hours and days the office is open (70% top ratings)
- Although patients who attend the TCC give overall high satisfaction ratings, challenge remains in ensuring all patients *attend* their agreed upon follow up appointments.
Team is brainstorming to identify ways to improve overall appointment attendance

Analysis/ Initial Follow-up Plans

- TCC patient satisfaction comment: “Later hours would be ideal for family members that work & would like to be at appointments”
- To better address the needs of working patients and their families, will look into ways to change scheduling hours at the TCC; perhaps 1 day in which patients are seen after working hours
- Reminder calls are made by a Team member, not “robo calls”. Team noted a high number of wrong numbers resulting in inability to reach patients for which a new technique is being tested. At the time Team is verifying demographic contact information, they explain that they are going to dial the number right then, “just to make sure I wrote your # down correctly”. While perhaps not the final answer to this problem, it minimizes the possibility of wrong contact numbers

Individual Patient Success Stories

- 64 year old admitted three times within a in 2 ½ month period for CHF; history of CHF, HTN, DM, Afib, active smoker and consumed at least 2 drinks daily. Team evaluation revealed that he had little understanding of his medical condition, poor disease management skills, and medication non-compliance due to cost of meds. Team worked with attending physician to switch meds to cheaper alternatives, assisted with \$ 4 plan as well as provided disease specific education. Follow up calls to patient to continue to coach and reinforce skills. Since working with Team, has attended follow up appointments in Center as well as with attending physician and has stopped drinking and smoking. He has been compliant with medications, appointments, and has remained out of the hospital and ED for more than one year
- 23 year old with CHF for 2 years with no understanding of disease, and how to self- manage illness. Acute exacerbation of CHF, came to ED and admitted. Team provided full CHF education with follow up in Center for reinforcement and check-up within 7 days post discharge. Patient brought mother to Center in order for her to learn too and arrangements for outpatient Cardiac Rehab made. Patient registered and attended 10 week Healthy Lifestyle classes, bringing family members along so they would learn as well. Has since been attending Cardiac Rehab and has been compliant with diet, medications, appointment follow -up with no additional admissions.